Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Physicians ASC 403 Treeline Park San Antonio, TX 78209	MFDR Tracking #: M4-07-4859-01 Inju En Insura
Respondent Name and Box #: Insurance Co of The State of PA Rep Box #19	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUM

Requestor's Position Summary: "Code not paid at DWC fee schedule or MAR conversion

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - $450.21
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: None Submitted

Principal Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes	Denial Codes	Part V Reference	Amount Ordered
10/05/06	23700-SG-RT	W1	1, 2, 3	$450.21
Total Due:				$450.21

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.402, titled *Ambulatory Surgical Center Fee Guidelines* effective after September 1, 2004, set out the reimbursement guidelines.

1. These services were paid an amount by the Respondent with reason code "W1-Workers Compensation Fee Schedule Adjustment."
2. Per §134.402, on DOS 10/05/06, CPT 23700-SG-RT performed at Requestor's ASC facility was reimbursed $232.43. This CPT is an ASC Group 1 code in Bexar County Reasonable Charge Locality (RCL) 7 (seven) reimbursable at $320.04 x 213.3% totaling $682.64. Therefore, an additional amount of $450.21 is due Requestor.
3. Per review of Box 32 on CMS-1500, zip code 78229 is located in Bexar County. The maximum reimbursement amount, under Rule 134.402, is determined by RCL.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, Section. 134.402
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to **an additional $450.21** reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $450.21 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

ORDER

[redacted] | [redacted] | 9-26-07

Authorized Signature | Medical Fee Dispute Resolution Officer | Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.